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RICHARD BLUMENTHAL
UNITED STATES SENATOR

TESTIMONY OF
UNITED STATES SENATOR RICHARD BLUMENTHAL
BEFORE THE
INSURANCE AND REAL ESTATE COMMITTEE
MARCH 13, 2014

I appreciate the opportunity to comment on Senate Bill 392, An Act Concerning Health Care Provider Network Adequacy and support the need to ensure that the health insurance networks in Connecticut appropriately serve the needs of the insured. For most insureds, the availability of a quality health care provider network with reasonable choices for health care services is of paramount importance.

SB 392 requires the Insurance Commissioner, in consultation with the Healthcare Advocate, to annually review all health insurance networks to ensure that they are adequately meeting the needs of insureds. Among the criteria that the Commissioner would consider is whether the networks include a sufficient number of geographically accessible health care providers in comparison to the number of enrollees, at least five primary care physicians within a reasonable distance and sufficient numbers of specialty providers.

Last year, patients who were insured through UnitedHealthCare Medicare Advantage plans were notified very late in the enrollment period that more than 2,000 health care providers in the UnitedHealthCare network would be terminated. My office received many calls from patients who were concerned about their continued access to their long-time physicians who would be covered under their Medicare Advantage policy. Hundreds of patients with critical health issues – and limited transportation means – were facing significantly longer distances between their home and their doctor's office. Distances that could pose insurmountable obstacles to obtaining timely health services. Their experience humanizes the critical nature of an adequate network

In response to the UnitedHealthCare mass terminations, I urged CMS to review of the adequacy of the remaining network. CMS' review was shallow and superficial, lacking in specific criteria for what an adequate network would constitute. In addition, I filed an amicus brief in support of the Fairfield and Hartford County Medical Societies' legal challenge to the UnitedHealthCare actions, calling on the United States Second Circuit Court of Appeals to uphold the district court injunction prohibiting the insurer from terminating the health care providers. The injunction was upheld with some modifications. Finally, I am sending the attached letter to the CMS Administrator Tavenner urging CMS to define significant changes to

health insurer networks and create a longer period of time for patients to fully understand network changes prior to determining whether to stay with their insurer or switch policies.

These concerns with the Medicare Advantage plans apply with equal force and importance to other health insurance plans to which thousands of Connecticut consumers pay millions of dollars and on which patients depend for vital, affordable health care services.

SB 392 establishes a framework for regulations that will ensure that patients have adequate choices for health care providers within their insurance network. I urge the committee to work with the Insurance Commissioner, the Healthcare Advocate, health care providers and other health care advocates to ensure that insurance plans provide sufficiently diverse networks to meet the critical needs of Connecticut patients.

March 12, 2014

Marilyn Tavenner
Administrator for the Centers for Medicare & Medicaid Services
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Tavenner,

We are writing in support of the Centers for Medicare and Medicaid Services (CMS) proposals in "Part C Provider Contract Termination Guidance" of the draft 2015 Call Letter to address consumer concerns related to network narrowing in Medicare Advantage (MA) plans. We also are submitting recommendations for additional steps CMS can take to protect seniors in MA plans.

As you are aware, this past fall United Healthcare terminated large numbers of health care providers from its MA plan networks in at least ten states, most dramatically in Connecticut and Rhode Island. In Connecticut, over two thousand providers were initially dropped. In Rhode Island, there have been reports that approximately 20 percent of physicians were terminated from United's MA provider network. The decision to narrow networks was made without adequate consumer protections in place and resulted in widespread confusion about the status of providers as in or out of network. We support CMS's proposal for defining and addressing concerns around "significant" changes to provider networks, and encourage the application of a uniform standard or threshold for "significant" across all MA plans. We recommend CMS consider a combination of factors when determining whether a network change is significant, including a percentage of physician types leaving a given network as well as the overall percentage of physician terminations. Certainly, we believe the terminations that recently occurred in Connecticut and Rhode Island constitute significant change, and look forward to working with you to ensure that any such definition adequately addresses these experiences.

In addition, seniors deserve to know what the provider networks in their MA plan will look like before they have to make decisions about enrolling in a particular plan. This includes a baseline assurance that all plans will provide an adequate provider network. We therefore recommend CMS verify that network adequacy standards are met before network adjustments are finalized. The verification of network adequacy should include considerations of access and continuity of care based on patient population, availability of specialty care, and geographic accessibility. We agree that MA organizations should provide CMS information about the steps the plan will take to ensure affected enrollees are able to locate new providers that meet their

individual needs. However, we urge CMS to require MA organizations to transmit this information rather than have such information be contingent upon a request from CMS. We also encourage CMS to consider requiring MA organizations to submit information about the number of continuity of care requests that they receive so CMS can confirm the plan is in compliance with applicable requirements. Both the MA organizations and CMS have an affirmative duty to ensure that seniors have access to the services that meet their individual needs regardless of whether they are in traditional Medicare or an MA plan.

We agree that plans should be required to notify CMS Regional Office Account Managers 90 days prior to the effective date of the planned termination. Particularly for significant network changes, additional notice to CMS would enable the agency to conduct oversight to verify that network adequacy standards are met before the changes are final. We also strongly support CMS's proposal to strengthen Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) materials. We endorse the proposed language concerning enrollees' rights should a plan make changes to its provider network during the year.

However, CMS should also require plans to provide specific, individually-tailored information about physician network changes in the ANOC. Notices to enrollees should clearly note that providers they are seeing or have seen will no longer be part of the MA plan's network. We recommend the notice follow the following format: "For the xxxx plan year, Dr. X (specialist in x), who you received treatment from on [Date], will no longer be a part of this MA plan and any services provided by him/her will not be covered through this MA plan." The notice should be accompanied by a comprehensive list of all primary care providers, all specialists, and healthcare facilities in the MA plan's geographic area that will no longer be in network the coming plan year.

On the provider side, we support CMS' proposal to afford providers more than 60 days' notice from the effective date of a contract termination, consistent with longer notification periods for plan enrollees. As noted by CMS, a longer period would give providers sufficient time to exercise their appeal rights and for the appeals process to conclude before affected enrollees are notified of network changes. In addition, we encourage CMS to use its rulemaking authority, as proposed, to broaden the agency's authority to limit MA organizations' ability to terminate provider contracts without cause at any time during the year. Limiting when such terminations can occur – in particular, prohibiting the termination of provider contracts during the annual election period – would assure seniors that the decisions they are making for the upcoming plan year are based on accurate plan network information. It is only fair that enrollees are privy to the information that the plan has about the networks at the initiation of the new contract.

In sum, we applaud CMS for taking significant steps to protect the interest of MA plan enrollees who are affected by provider network terminations. We urge CMS to incorporate our suggestions into the final 2015 Call Letter and pursue additional rulemaking as indicated.

We appreciate your attention to these issues, and look forward to reviewing the final Call Letter.